CHANGING Maryland *for the Better*

Medicaid Community Options

Course 2: Eligibility

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Where are People Before They Enter Our Programs?

- In the community:
  - A community Medicaid eligible person living in their home may be able to receive services under CPAS or CFC.
  - They normally contact the Department or their local Maryland Access Point to check for eligibility.
- In a nursing facility:
  - Most participants transitioning out of a nursing facility go into the Community Options Waiver.
  - The Money Follows the Person Program assists in this transition.

Enrollment Timeline: Community Applicants (CFC/CPAS)

1. Check for Eligibility
2. Assess for Needs
3. Develop a Plan of Service
4. Enroll and Begin Services

Moving out of a Nursing Facility - Money Follows the Person Program

- Maryland's Money Follows the Person (MFP) demonstration is a grant designed to rebalance long term services and supports to increase HCBS as an alternative to institutional care
- MFP services include:
  - Options Counseling
  - Peer Outreach
  - Flexible Transition Funds
  - Housing Assistance
- Has specific eligibility requirements

Enrollment Timeline: Nursing Facility Applicants (CO/ICS)

1. Apply for Wavier Services
2. Assess for Needs
3. Develop a Plan of Service
4. Transition to Community
5. Enroll and Begin Services

What Eligibility Criteria Does the Person Need Before Receiving Services?

- All Medicaid programs require that eligibility standards be met prior to accessing services.
  - Technical
  - Medical
  - Financial

Technical Eligibility

- To be in the Community Options Waiver, a participant must be 18 years of age or older.
  - CFC and CPAS do not have an age requirement.
- Community Options Waiver participants have slightly different requirements for community residence.
  - CO Waiver participants may elect to stay in an assisted living facility. CFC and CPAS participants may not receive assisted living facility benefits.

Technical Eligibility – Community Residence

- To be eligible for CFC and CPAS, the participant must reside in a community residence. This means that the participant has:
  - Access to the community and community services,
  - Control over choice of roommates,
  - Choice of if and when to receive visitors,
  - Access to food at any time, and
  - Privacy and locks.
  - The residence must be physically accessible to the participant.
  - Any restrictions on the activities of the participant cannot be for the convenience of the caregiver.
  - The living arrangement must be subject to the normal landlord-tenant or real property laws of the jurisdiction.
- CMS Toolkit on the community definition released on March 2014
  - Available at Medicaid.gov

Technical Eligibility – Community Settings Questionnaire

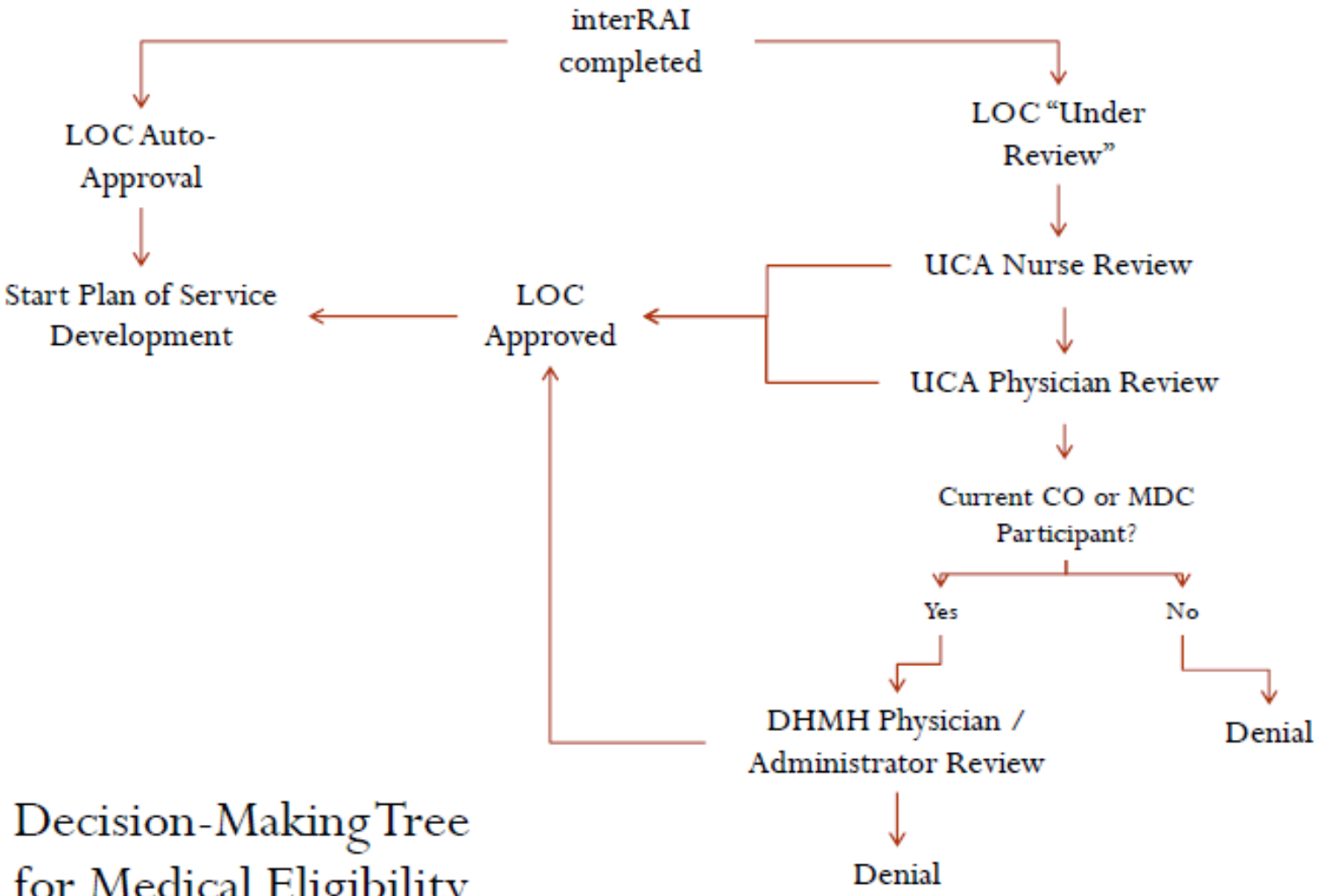
- The Community Settings Questionnaire (CSQ) is required
  - Annually, and
  - At the quarterly visit, if there is a change in residence.
- The CSQ is submitted by the Supports Planner in the LTSSMaryland System and reviewed by the Department if necessary.
- Community Settings Questionnaire

Medical Eligibility – interRAI-Home Care Assessment

- The interRAI is administered by the individual's Local Health Department (LHD).
  - The interRAI must be completed for all program participants without exception.
- There are two types of medical eligibility for these programs:
  - CPAS Level of Care
    - Only requires one ADL assistance.
    - CPAS program serves participants with fewer health needs.
  - Institutional Level of Care
    - Required for Community First Choice, Community Options and Increased Community Services
    - Nursing facility level of care (NF LOC) is the most common for these programs.
    - Other types of institutional levels of care (ICF-ID and Chronic Hospital) exist however are not as common in these programs.
- The interRAI results determine CPAS LOC and/or NF LOC

Medical Eligibility – Utilization Control Agent

- CPAS and NF LOC approvals are automatically determined in the LTSSMaryland system.
- If a level cannot be approved automatically, the Department's Utilization Control Agent (UCA), currently Telligen, reviews the InterRAI and other medical information as necessary.
- UCA has a two-tiered system of reviewing (nurse review, then physician review).
  - If the LOC is denied by the UCA nurse, the UCA physician will review the decision.
    - This decision is final for new applicants.
  - If the person is currently enrolled in CO or MDC, the DHMH physician will review the denial.
- No one is denied level of care without a nurse and physician reviewing their medical information.



Decision-Making Tree for Medical Eligibility

Medical Eligibility – Community Personal Assistance Services (CPAS)

- Individuals must meet CPAS LOC
  - Requires assistance with one ADL
- Assessment of medical needs is performed by the LHD upon application, annually or if there is a significant change in health status

Medical Eligibility – Community First Choice (CFC) and Community Options (CO) Waiver

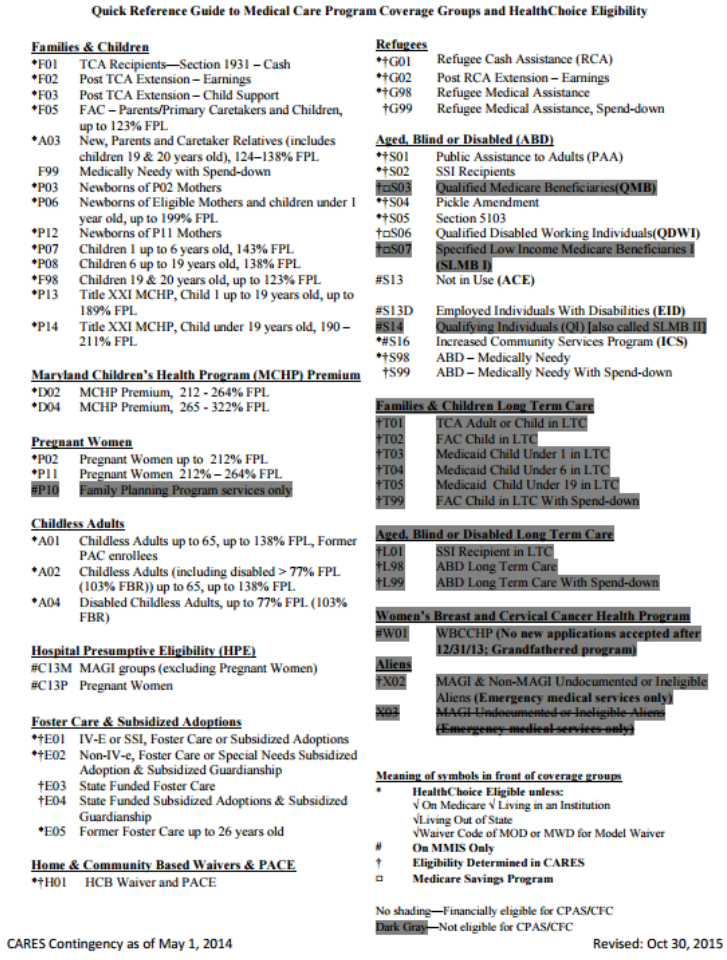
- The individual must meet institutional level of care.
  - In most cases, this is determined from the process previously described.
- An institutional level of care is required for all waiver programs.
  - Community Options, Community Pathways, Autism, Brain Injury, Medical Day Care, Model.
  - If the InterRAI does not provide a LOC approval but the person is enrolled in another waiver program, they would meet the CFC medical eligibility criteria.

Financial Eligibility – Community First Choice (CFC) and Community Personal Assistance Services (CPAS)

- Participants must be eligible for Medicaid under the State Plan, and be in a coverage group under the State Plan that includes nursing facility services
- **Community Medical Assistance** eligibility is determined by the **Department of Social Services.**
  - When a person is enrolled in Medicaid, they receive a three-digit coverage group for which they are eligible.
- If an individual does not have Medical Assistance and would like to apply, they would need to do so at their local Department of Social Services.

Coverage Groups

- See Quick Reference Guide to Medical Care Program Coverage Groups and HealthChoice Eligibility for eligible coverage groups
- If a group is shaded, they are not eligible for CPAS or CFC
  - QMB (S03) and SLMB (S07, S14) Medicaid participants are not eligible for CFC or CPAS.



Quick Reference Guide to Medical Care Program Coverage Groups and HealthChoice Eligibility

Families & Children
- *F01 TCA Recipients—Section 1931 – Cash
- *F02 Post TCA Extension – Earnings
- *F03 Post TCA Extension – Child Support
- *F05 FAC – Parents/Primary Caretakers and Children, up to 123% FPL
- *A03 New, Parents and Caretaker Relatives (includes children 19 & 20 years old), 124–138% FPL
- F99 Medically Needy with Spend-down
- *P03 Newborns of P02 Mothers
- *P06 Newborns of Eligible Mothers and children under 1 year old, up to 199% FPL
- *P12 Newborns of P11 Mothers
- *P07 Children 1 up to 6 years old, 143% FPL
- *P08 Children 6 up to 19 years old, 138% FPL
- *F98 Children 19 & 20 years old, up to 123% FPL
- *P13 Title XXI MCHP, Child 1 up to 19 years old, up to 189% FPL
- *P14 Title XXI MCHP, Child under 19 years old, 190 – 211% FPL

Maryland Children's Health Program (MCHP) Premium
- *D02 MCHP Premium, 212 - 264% FPL
- *D04 MCHP Premium, 265 - 322% FPL

Pregnant Women
- *P02 Pregnant Women up to 212% FPL
- *P11 Pregnant Women 212% – 264% FPL
- #P10 Family Planning Program services only

Childless Adults
- *A01 Childless Adults up to 65, up to 138% FPL, Former PAC enrollees
- *A02 Childless Adults (including disabled > 77% FPL (103% FBR)) up to 65, up to 138% FPL
- *A04 Disabled Childless Adults, up to 77% FPL (103% FBR)

Hospital Presumptive Eligibility (HPE)
- #C13M MAGI groups (excluding Pregnant Women)
- #C13P Pregnant Women

Foster Care & Subsidized Adoptions
- *†E01 IV-E or SSI, Foster Care or Subsidized Adoptions
- *†E02 Non-IV-e, Foster Care or Special Needs Subsidized Adoption & Subsidized Guardianship
- †E03 State Funded Foster Care
- †E04 State Funded Subsidized Adoptions & Subsidized Guardianship
- *E05 Former Foster Care up to 26 years old

Home & Community Based Waivers & PACE
- *†H01 HCB Waiver and PACE

Refugees
- *†G01 Refugee Cash Assistance (RCA)
- *†G02 Post RCA Extension – Earnings
- *†G98 Refugee Medical Assistance
- †G99 Refugee Medical Assistance, Spend-down

Aged, Blind or Disabled (ABD)
- *†S01 Public Assistance to Adults (PAA)
- *†S02 SSI Recipients
- †□S03 Qualified Medicare Beneficiaries**(QMB)**
- *†S04 Pickle Amendment
- *†S05 Section 5103
- †□S06 Qualified Disabled Working Individuals**(QDWI)**
- †□S07 Specified Low Income Medicare Beneficiaries I **(SLMB I)**
- #S13 Not in Use **(ACE)**
- #S13D Employed Individuals With Disabilities **(EID)**
- #S14 Qualifying Individuals (QI) [also called SLMB II]
- *#S16 Increased Community Services Program **(ICS)**
- *†S98 ABD – Medically Needy
- †S99 ABD – Medically Needy With Spend-down

Families & Children Long Term Care
- †T01 TCA Adult or Child in LTC
- †T02 FAC Child in LTC
- †T03 Medicaid Child Under 1 in LTC
- †T04 Medicaid Child Under 6 in LTC
- †T05 Medicaid Child Under 19 in LTC
- †T99 FAC Child in LTC With Spend-down

Aged, Blind or Disabled Long Term Care
- †L01 SSI Recipient in LTC
- †L98 ABD Long Term Care
- †L99 ABD Long Term Care With Spend-down

Women's Breast and Cervical Cancer Health Program
- #W01 WBCCHP **(No new applications accepted after 12/31/13; Grandfathered program)**

Aliens
- †X02 MAGI & Non-MAGI Undocumented or Ineligible Aliens **(Emergency medical services only)**
- ~~X02 MAGI Undocumented or Ineligible Aliens (Emergency medical services only)~~

Meaning of symbols in front of coverage groups
- * **HealthChoice Eligible unless:** √ On Medicare √ Living in an Institution √Living Out of State √Waiver Code of MOD or MWD for Model Waiver
- # **On MMIS Only**
- † **Eligibility Determined in CARES**
- □ **Medicare Savings Program**

No shading—Financially eligible for CPAS/CFC
Dark Gray—Not eligible for CPAS/CFC

CARES Contingency as of May 1, 2014

Revised: Oct 30, 2015

Financial Eligibility – Community Options (CO) Waiver

- **Waiver applicants** apply through DHMH's **Eligibility Determinations Division (EDD).**
  - They do not apply through the local DSS for waiver services.
- Eligibility is based on both income and assets. The monthly income limit is based on 300% of SSI. In 2016 the income standard is $2,199. Assets may not exceed $2,000 or $2,500 depending on eligibility category. The income standard changes annually in January.

Financial Eligibility – Increased Community Services (ICS)

- **ICS applicants** apply through DHMH's **Eligibility Determinations Division (EDD).**
  - Individuals are only eligible to apply after being denied for a waiver program due to over scale income.
  - They do not apply through the local DSS for waiver services.
- ICS allows individuals residing in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community, while permitting them to keep income up to 300 percent of SSI.

Special Program Codes

- While coverage groups denote overall Medicaid eligibility, special program codes denote the program a person is in within Medicaid.
  - Some programs do not have a special program code.
  - Special program codes are also three digits.
- For instance,
  - A person in the Community Options Waiver will have one of four codes (OAA, OAM, OHM, or OAH).
  - A person in the ICS program will have one of two codes (ICS or ICM).
  - CFC and CPAS do not have special program codes.
- Special Program Code List

Program	Special Program Code	Key
Model Waiver	MOD	Model Waiver-Deinstitutionalized
	MWD	Model Waiver-Diverted
Autism Waiver	AUT	Autism Waiver
Community Pathways (Waiver)	MRW	Intellectual Disability, deinstitutionalized
	DRW	Intellectual Disability, diverted
	NRX	Developmentally disabled, diverted
	DRM	MFP - Intellectual Disability, diverted
	NRM	MFP - Developmentally disabled, deinstitutionalized
New Directions (Waiver)	NRW	Developmentally disabled, deinstitutionalized
	MRM	MFP Intellectual Disability, deinstitutionalized
Brain Injury Waiver	TBW	Brain Injury Waiver
	TBM	MFP-Brain Injury Waiver
Living at Home Waiver	ACD	Living at Home-Deinstitutionalized
No Longer in Use	ACI	Living at Home-Diverted
	ACM	MFP-Living at Home
Residential Treatment Center Waiver	RTC	RTC Waiver
Community Options	OAA	Community Options Waiver-Assisted Living
	OAH	Community OptionsWaiver-Private residence
	OHM	MFP - Community OptionsWaiver-Private residence
	OAM	MFP - Community Options Waiver-Assisted Living
Rare and Expensive Medicine	APD	Asymptomatic Pediatric Disease
	BLD	Blood Disease
	CON	Congenital Anomalies
	DEG	Degenerative Disease
	IID	Infant with Inconclusive Disease
	MET	Metabolic
	PSA	Pediatric Symptomatic Disease
	VDP	Ventilator Dependent Person
	OTH	Other
Hospice	HOS	Hospice
Medical Day Care	MDC	Medical Day Care
Increased Community Services	ICS	Increased Community Services
	ICM	MFP-Increased Community Services
Behavioral Health Homes	BHH	Behavioral Health Homes
Money Follows the Person	MFP	State-plan only MFP, no waiver services